SMALL BUSINESS
Association of MICHIGAN

Supplemental Testimony on Cost of Health Care
House Health Policy Committee

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About

The Small Business Association of Michigan has a long history of providing health insurance and employee benefits programs to its member businesses and their employees. It is based up this history that we submit the following for consideration as the debate over repeal, repeal and replace or repeal and repair rages on in the halls of Congress.

Ideas We Favor

Expansion of HSAs

Health Savings Accounts should be expanded. We agree with the approach of Sen. Rand Paul including income tax credits of up to $5,000 per year for contributions to an HSA, and the maximum limits for HSA contributions being removed even if they exceed the $5,000 level. Further, removing the requirement that one must be in a qualified high deductible plan ("HDHP") in order to contribute to an HAS make good sense. This means that those on Medicare, Tri-Care or in the VA can also have HSA accounts. Monthly insurance premiums can also be paid for from an HSA under Sen. Paul's proposal. Individuals can also now purchase fitness equipment, and pay for prescriptions and over-the-counter drugs with an HSA under this proposal. Finally, HSA funds would now be protected in the event of bankruptcy.

Consumerism, Transparency and Measuring Success or Failure

For HSAs to be successful, individuals must be able to compare costs and quality of services being provided. Therefore, what is going on inside of the physician's office, hospitals and outpatient facilities must be measured and made available to the public. Transparency - providing comparative data on health costs, quality, infection, morbidity and mortality rates inside facilities must be improved. *Leapfrog Group* style reporting for medical providers would be a good start.

High-Risk Pools and Subsidies

Overall, SBAM believes that any subsidies should subsidize the right thing(s). There are many subsidies in today's health care world including the subsidization of Medicaid costs to the individual and employer health insurance pools (Medicaid pays cents on the dollar), subsidization of the uninsured, subsidization of the low income population and subsidization of individuals that are uninsurable. What we subsidize and how the costs are spread needs to be reviewed.

A great challenge for health care reform is getting healthy individuals (many young and invincible) enrolled. Many continue to take a pass and pay the penalty because they have done their own cost benefit analysis and determined that they will take their chances and stay uninsured. What if insurance costs were reduced substantially for these individuals and small groups through an effective use of a well thought out and funded High-Risk Pool where

individuals with a known, costly medical condition(s) could obtain coverage for themselves with the cost mutualized/subsidized very broadly across all taxpayers? Would the same decisions be made?

Additionally, the current subsidies of the ACA are not available for the catastrophic plan (the special plan for young people just below Bronze). If subsidies are continued, this distinction should be eliminated so that new entrants to the work force can get low cost coverage that meets their needs. To protect against adverse selection, this subsidy could be phased out after five years if the person still meets the criteria for enrollment in this low cost option.

Guarantee Issue, Pre-Ex Conditions, Continuous Coverage and Underwriting

Eliminating the individual mandate, while at the same time retaining guarantee issue and the limitation on pre-existing conditions, will prove challenging. Both impact the small group market in much the same way as they impact the individual market. Finding a way to balance these with the need to maintain the risk pool will prove difficult.

It is clear that the "penalties" for failure to enroll in a health plan are too low ($695 or 2.5% of income in 2017) and nearly unenforceable which has led to much "gaming of the system" where individuals enroll for short durations of time, obtain care and then cancel their insurance plan. This practice has led to many carriers losing hundreds of millions of dollars on the individual market.

To address this, a more significant penalty along the lines of that used by Medicare (10% increase in cost forever, and up to a one-year delay in enrollment) may be considered for those who fail to enroll when eligible. This rule has been in Medicare for generations and seems to work well.

A second option to be considered for the individual and small group markets is an open enrollment period during which insurance plans are guaranteed with no, or limited, pre-existing conditions. The question around open enrollment is how often and for how long and what keeps an individual or small group enrolled? Should there be a one-time open enrollment or annual open enrollment? To accomplish any of this, there must be one set of common underwriting regulations for insurance carriers developed at the federal level, reviewed and enforced at the state level.

These underwriting regulations would include:

- 5:1 rate bands.
- Requirements to use single, two-party and family rates at the composite level.
- Common and reviewable scoring of medical conditions.
- Continuous coverage rules would allow an argument for a one-time open enrollment. As long as an individual or small group maintains coverage with no breaks in excess of 30/60 days, they should be free to move from carrier to carrier (and market to market) with no threat of denial or pre-existing condition.

- Movement across carriers should be limited to one time annually, during an open enrollment window.
- Individuals who choose not to enroll or have a break in coverage would be subject to the penalty described above, potential denial (underwritten to a high risk pool), be subject to pre-existing conditions (6/24) or a combination of the above.
- Carriers would have an annual opportunity to export an individual with a serious medical condition (that will require subsidization) to the High Risk Pool.

Definition of a Small Business for Reasons of Health Insurance Purchasing

Companies with as few a one employee (sole proprietor) and as many as ninety-nine employees. This allows a bona fide small business to enroll via the small group pools and expands the definition to include all companies below 100 employees.

Adjust the Definition of Full-time Employee/ ACA Reporting/Measurement Period

Return the definition of full-time to 40 hours per week (currently defined as 30 in the ACA).

Eliminate or modify tracking of Full Time Employee (FTE) hours. The ACA mandates a complicated and expensive data reporting to determine if an employer is an Applicable Large Employer (ALE) under the ACA and whether an employee is an FTE so that an employer would be required to provide health insurance or face a penalty.

Coverage to 26

Allowing children to maintain coverage until their 26th birthday on their parent's health insurance plan. We support this for a number of reasons including the impact that this has had on the number of young people being insured.

Adjust Rating Bands and Member Level Rating

Reconsider the ACA required 3:1 age bands that have driven rates up for the young, uninsured, where cost is a barrier. Moving back to 5:1 would provide relief for the cost of younger Americans.

Eliminate the member level rating and return to simple to understand and administer single, two-party and family rates (and take the target off the backs of the 50+ age worker).

Eliminate Health Insurance Tax

Repeal the annual fee on health carriers – this tax is simply being passed along to the rate payers. If repealed, should there be a rebate or rate adjustment for those now paying this in their insurance premium (talk is of a retroactive repeal)?

Eliminate the Employer Mandate

We support eliminating this mandate. Along with the mandate, the definitions of a large and small employer, part-time, seasonal, variable, measurement period, stability period, administrative period and everything else that goes into this calculation should also be eliminated.

State Flexibility - Medicaid Expansion's Future

For states who have elected Medicaid expansion, it would be wise to expand the opportunity to obtain Medicaid "waivers" to allow them to try innovative models to make Medicaid more market based and flexible. Medicaid Block Grants allow states the flexibility to determine how best to structure the benefits to fit their state needs. Examples would be continuous enrollment approaches to avoid annual requalification, block grants to enable states to modify benefits and benefit administration, etc. The Healthy Michigan Plan (Michigan's Medicaid Expansion method) may be a model to consider nationally.

Allowing states to take the Medicaid expansion funds and allow citizens to use those to buy private insurance through the Exchange, rather than being forced into Medicaid if they want more choice, etc.

Cadillac Tax

Two of the greatest issues with the Cadillac Tax are the geographical nature of health care costs and that the tax does not recognize benefit levels. The concept is sound, but should be adjusted to reflect the plan design being purchased and not the underlying health care costs of the area of the country being considered and/or the age of the employee population of the employer plan.

Deduction for premiums/Level the Playing Field

SBAM has long argued that the tax code is unfair in that individuals have different tax treatment on their premiums than do employees of large companies. Premiums for plans should be deductible.

Wellness Plans

A conflict exists in the regulation of wellness plans. The EOC and DOL have recently ruled on cases which significantly restrict an employer's ability to implement a wellness plan to help improve employees' health status and productivity. These rulings fly in the face of the efforts by the IRS to implement regulations regarding the opportunities for such plans under the ACA.

Congress should enact legislation to clarify the employer's right to implement wellness plans as provided for in the ACA without the interference by the EOC/DOL.

Ideas Needing Additional Thought

The HRA expansion

Some have argued that the IRS' restriction on employers' ability to establish a Health Reimbursement Arrangement ("HRA") that enables them to use tax advantaged funds for the purchase of individual insurance purchased by employees outside of their employment is too restrictive. This concept has raged on for years. It started with a few enterprising individual insurance companies, and their agents, who sought to use this approach to get around the protections in the HIPAA health reforms for small groups. Then, when the ACA was passed, the effort continued (although now with all insurance on a guaranteed issue basis).

The conceptual issue arises when a small employer has young employees who can obtain individual health plans less expensively by applying on their own, versus through their employer. The rating differential is based upon the fact that the individual plans do not have to comply with all of the provisions of the ACA, and state reforms, for small group plans. These policies are, therefore, less expensive.

Our concern is that this approach "games the system" in that the young who are healthy and do not need the level of coverage required by small group plans (maternity, mental health, etc.) are able to obtain less comprehensive coverage on their own with tax advantaged premiums. The result is that we have higher rates for small group plans which causes fewer young individuals to be enrolled in them.

This argument should not be positioned as being "pro insurer" versus "pro small employer." Rather, it is intended to ensure that gaming does not occur which impacts everyone in the market and weakens the ability for small employers to obtain affordable group coverage.

Selling Across State Lines

This is a great sound bite – of course insurance should be able to be sold across state lines. This is America after all; it doesn't matter what state you are in, you can make a decision to buy a Ford, Chevy, BMW so why should health insurance be any different? Well, because it is different.

We believe that beyond the hope of increased competition that the question of selling across state lines is actually a question of who is regulating the health insurance market. Should individual states continue as the primary regulators as they have been for decades or should the federal government regulate the market? At the end of the day, this argument may boil down to a States' Rights question.

When people say that health insurance should be able to be sold across state lines, what they are hoping for is that somehow insurance sold in a state with lower premiums will somehow be sold for the same price in states with higher premiums and, therefore, competition will be increased. That is the hope. What they are really saying is that some states are over-regulated and that they would like the insurance carriers to be able to pick the state whose regulations they would follow for things like the number of mandated benefits, network adequacy, reserve requirements and things like that. We would generally agree that some states have taken regulating the health insurance market to the extremes, especially with some of the mandates that have been passed into law. We would agree that over-regulation does drive health insurance costs higher. However, these issues play at the margins.

Allowing health insurance carriers to sell across state lines will most likely not increase the number of carriers in a given market. This is due primarily to a couple of reasons: networks and market share and claims experience. When you examine the claims experience of a health insurance plan, you find that the vast majority of costs are from big ticket health insurance claims for chronic diseases, beginning and end of life care, major surgeries and those sort of items. So regardless of the state regulating the health insurance carriers, most of the costs are generated locally and the real dollars being spent are in the claims being paid. What claims are paid is highly dependent on the enrollment into the carrier's pools, the health of the individuals that the carrier is covering, the frequency of claims, and what are the negotiated discounts between the carrier and the hospitals, physicians and pharmaceutical manufacturers/suppliers, etc.

Think of it this way; in many markets we have big national carriers already selling in many states – these carriers would include United HealthCare, Aetna, Humana, Anthem and several others. Allowing regulations to be under one state may save these carriers minor administrative costs and may cut out a few mandates here and there, but big costs savings are hard to imagine. Additionally, allowing insurance carriers to pick the state they chose to be regulated under would be a concern of local Departments of Insurance across the country when issues of regulatory authority come into question.

Association Health Plans

The thought of Association Health Plans goes back to the mid-1980s. They were First promoted by a small insurance carrier – Golden Rule - who was looking for a market advantage over some of their competitors and then adopted by some policymakers looking for ways to encourage small business owners to offer health insurance to their employees. The idea is that associations like the Small Business Association of Michigan, or the Council of Small Enterprises in Cleveland, Arizona Small Business Association or others would negotiate for better rates and better coverage for the members of their associations.

Maybe, but maybe not. These questions need to be answered first: what is the Association Health Plan actually doing? With whom are they negotiating? Are they negotiating with insurance carriers, health care providers, both? Can anyone expect that an association would have more clout with health insurance providers that the dominate insurance carrier in their region? I will use SBAM as an example. Our health plan has roughly 35,000 employees enrolled, roughly 90,000 people. Given that size we are only about 15% of the small group pool of BCBSM. We would love to be able to negotiate with BCBSM on administrative issues while leveraging their power with providers.

Again, this is a bit like selling across state lines, where the devil is in the details. Some of the considerations to think about include:

- Regulations – who is overseeing the Association Health Plan? Is it the state government, federal government, no one?
- What are the reserve requirements for solvency, what IBNR figure are they using?
- What safeguards are in place to protect the long-term viability of the program and protect the members of the Association? Anyone can have a low rate in the first year or two, but what about the out years?
- What are the target loss ratios, what are the attachment points for reinsurance?
- What benefits are covered?
- Is coverage guaranteed to all members of the Association or can members be screened out? What kind of Association can have a plan? Vertical trade Associations, Chambers of Commerce, etc.

The last time there was significant discussion around Association Health Plans was in the mid-1980s and, at that time, SBAM was skeptical. That may sound odd coming from SBAM, an organization with a health plan for its members. But again, the devil is in the details. We were skeptical because we were reacting to a specific piece of legislation at the time. We expect that same legislation may get the dust blown off of it and be back for the next round of discussions.

The caution then and maybe now:

- Will an Association Health Plan help anything at the macro level? Health care costs are like the air in a balloon, squeezing one end simply forces the air to the other. We are afraid that if the AHP was successful and reduced the costs for its members, their savings would be someone else's to absorb.
- AHP supporters will argue that the administrative costs for an AHP will be more in line with those of a large self-insured employer's plan. Probably not the case in reality. The AHP will still have some marketing and sales costs, re-insurance fees, morbidity charges, etc. Those do not apply in a large company's self-insured costs. That comparison is an apples and oranges comparison.
- Much like selling across state lines, who regulates the Association Health plan is an important consideration. AHPs could be in many ways similar to another animal called a

MEWA – Multiple Employer Welfare Arrangement. Done for the right reasons and done right with proper planning, oversight and management they can work, but there is also a not so great history of many MEWAs failing and leaving the members with unpaid claims.

The bottom-line to both Selling Across State Line and Association Health Plans – they play at the edges. Could they help save some small business owners some amount of money? Maybe. The hope that they will somehow be the savior of the small group health insurance market is probably well overstated. It is not that simple.

Cost is the Issue

Health insurance costs what it costs because of the high cost of health care, the general health of the population and the frequency of care being received.

- Reducing readmissions /doing things right - Promoting Best Practices and/or Centers of Excellence for health care services and greatly reducing the rate of infection within our hospitals.

- Restraining the growth of pharmacy costs. The focus must be on proven products vs. chasing the "bright lights", effective medical management and higher generic usage.

- Payment Reform/Pay for Performance – Bundled payments along with bonuses/withholds should be considered along with the ability for payers (carriers or self-insured groups) to stop paying for "never-events."

- Medical Malpractice

  Reform of our Medical Malpractice System – health courts. The ACA's five-year demonstration grants to states will do little, if any, good.

- Provider Consolidation

  The consolidation of hospital systems (and other providers including pharmaceutical companies) is something to be watched very closely over the coming years – what will consolidation mean to both the cost and quality of care being delivered?

- Health Literacy

  The least expensive health insurance claim is one that is avoided. Everyday decisions have a significant impact on our health and many of these decisions impact the need for medical attention and the amount of resources expended to obtain required care. An effort must be made to increase the degree to which individuals have the ability to obtain, process, and understand basic health information and services required to make appropriate health care and health care financing decisions.

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